D. C. Brown

Family Practice— What's the Difference?

SUMMARY

Twelve significant differences of family practice are presented with supporting information from the literature. Seven differences between family physicians and other primary care physicians are presented. (Can Fam Physician 25:1484-1487, 1979).

Dr. Brown, a certificant of the College, is an associate professor of family medicine at Dalhousie University. Reprint requests to: Dept. of Family Medicine, Dalhousie University, 5599 Fenwick St., Halifax, NS. B3H 1R2.

I AM what I *do*, not what I say I am.

Family medicine is the academic discipline, composed of knowledge, skills and attitudes. Family practice is the application of that knowledge in a system of medical care. Much has been written about family medicine in books and journals;[1-8] it differs from the rest of medicine in general and other primary care 'providers' in particular.

Significant Differences

Number One

Dr. Lynn Carmichael stated that: "An important component in the definition of the family physician is that he has a *'tenured relationship'* in which the doctor and the family members have mutually agreed upon obligations."[9] No other physician has this unwritten contract with patients of all ages and with the whole family. No other physician will say "No matter what your problem I will see you".

Number Two

Dr. Ian McWhinney has introduced this second major difference of family practice: that of the "unselected problem". "The family physician differs from all other physicians in that he can make no tacit assumptions about the problem he is likely to encounter. Implicit in his role as primary physician is his availability for all types of disorder. He must have a method which is flexible enough to be adapted to any presenting problem."[10]

TABLE 1

The Significant Differences Of Family Practice

1. Tenured relationship with the family.
2. First contact physician for patients with unselected problems.
3. The family is the unit of care.
4. Coordinating role.
5. Early diagnosis by selective screening and patient-centred medicine beyond diagnosis.
6. Continuity of care.
7. Nature of the doctor-patient relationship.
   —Awareness of the whole patient in family and community context.
   —Many "strings of attachment".
8. A different counselling and psychotherapeutic approach.
9. Whole person approach.
10. The problems are different.
11. The volume of patients is larger.
12. Family practices are heterogeneous.

Number Three

Family physicians are available to give care to all members of the family: "Their commitment is to a group of people more than to a body of knowledge".[11]

"The family physician looked after all members of the family in 86% of cases. It was from this fact that the term 'family medicine' developed and the College changed its name to the College of Family Physicians of Canada."[12]

Browne and Freeling express very 3clearly two important aspects of the family physician's relationship with families: "Under the guise of physical or emotional illness, the family doctor is often presented with problems in family relationships . . . the family doctor, with his special position of trust and of access to the family circle, is in a unique position, shared by no specialist, to be able to understand and make the deeper diagnosis of the disordered relationship. In this situation, often in the process of diagnosis, he may be enabled to trigger a change in family conditioning which may have a profound impact on the subsequent emotional, and consequently physical, health of all the family members."[13]

Another author has commented: "The struggle within the family for the power and privilege of sickness intimately involves the family doctor. But how does it involve him? How will he act? As an alibi, a witness for

the defence, a medical policeman, a clinical magistrate?"[14]

I believe many family doctors counsel families on the majority of problems they present. This is supported by a search of the literature which shows that 20-30% of the family doctor's day is spent dealing with emotional and psychological problems. Marital problems are the most common of these, followed by depression, hypochondriacal problems, alcoholism, chronic illness and anxiety or tension states.[15] The family physician is in an excellent position to study the impact of illness on the family and the influence of the family on illness. There are a number of books and articles on this subject.[16-19]

The best summary I have heard about what differentiates family physicians from other physicians came from a rural family doctor: "Family physicians take the time to assess the family, to find out if they are part of the problem or part of the solution, and to assess how their attitudes can be changed or harnessed in promoting health."[20]

Even though controversy exists about what constitutes a family and what its functions are, social scientists agree that its existence is common to all human societies. This makes it an appropriate and universal unit of care.[21]

Number Four

A coordinating role is the fourth function that distinguishes the family doctor from other physicians. "This function has increased in importance as medicine has become more highly specialized and complex and as patients have become more medically sophisticated and better able to participate actively in their own care . . . the family physician insures continuity and comprehensiveness of medical care. This is one of his most important functions . . . the family physician provides leadership for the many allied personnel who offer services for his patients."[22]

Dr. E. D. Pellegrino stated this function of the family physician most deftly: "Generalists must, therefore, coordinate and manage the input of specialists and other health professionals, they must deal in an orderly fashion with multiple problems, they must make the confusing whole into an intelligible situation for the patient and his family, and they must assume personal responsibility to protect the patient's interests in what is often an overwhelming array of treatments, recommendations, and techniques. The generalist must explain the relative importance and priorities of what can be contradictory recommendations offered by the specialists. He has a particularly difficult moral responsibility to protect the patient from the overzealous espousal of the consultant's preferred technique, to the exclusion of other equally tenable alternatives."[23]

Number Five

The fifth function that distinguishes the family physician from other physicians is hard to define. It encompasses prevention and 'anticipatory guidance', especially at crucial times in family and individual development.[24, 25]

Professor Marinker clearly describes the process of sorting out symptoms which may be related to family discord: "First there is the problem of identifying the patient at any particular moment. Who is the patient? Is it Sara? Is it her mother? Is it her father? Michael Balint recognized three categories of patients: the presenting patient; the key patient, and the treatable one."[14]

Patient education is an important aspect of anticipatory guidance and a large part of the family physician's health care approach.[26, 27] Then, too, his special knowledge of the patient and his family allows him to engage in health promotion.[28]

Different doctors have different 'diagnostic thresholds', as a recent article points out: "In all cases, the practitioners who graduated after 1950 were more apt to see emotional illness than were those who graduated prior to that year."[29]

Part of this aspect includes intuition about the patient and his perception of his condition: "The needs of the patient may not be expressed in words and have to be discovered by the doctor's investigation and even intuition. To satisfy such a patient does not mean simply to satisfy the patient's expressed wishes, but to fulfil deeper, often unconscious needs, the elucidation of which requires complex and refined techniques. The kind of medicine that takes into account these needs and satisfactions is well described as 'patient-centred medicine' ".[30]

Many patients with emotional symptoms are discouraged human beings with low self-esteem who feel incapable of influencing others in a positive way. The physician must understand the person's outlook on life and his view of himself in relation to his environment.[31, 32]

Collyer's 12 month study of his own practice showed that he performed 6,268 services. Of all his office visits, 17% were for psychotherapy.[33] A 1972 survey revealed that United States family doctors spend one-fifth of their working time counselling patients for emotional problems. The doctors responding spent 17.1%-27.5% of their time counselling on premarital and marital problems, drug and alcohol abuse, and individual adjustment problems.[34]

McWhinney integrates behavioral science and clinical medicine as follows: "A useful system for classifying patient behavior at the point of contact with the physician has five categories: attendance with symptoms or problems that have reached the limit of tolerance; attendance with symptoms that provoke action because of their implications; problems of living; administrative reasons (certificate for an illness); and attendance for reasons other than illness (well baby care or check up)."[35]

This fifth distinguishing function might be summarized by saying the family physician is dealing more with health care than illness care, more with dys-ease care than disease care, more with early diagnosis than advanced disease, more with unorganized disease than disease of an organ system, more with anticipatory guidance than with rehabilitation, more with searching for the real problem than with diagnosing the disease, more with family relationship problems than with hereditary disease.

Number Six

Continuity of care[36] is the sixth function distinguishing the family physician.

The family physician provides continuing care, for all ages from newborn to the elderly, including the dying process; for all members of the family unit; for those who require the coordination of several consultants or agencies.

"The tools of our specialty, in psychological terms, are: the five-minute psychotherapy session; the longterm relationship; the use of separate and unrelated events to reinforce or redevelop that relationship over many years, so that the patient may trust his

doctor in any situation in which they may relate."[37]

These tools give the family doctor an advantage,[38] but also "impose on us the hard but necessary discipline of living with our results, both good and bad . . . No wonder we are conservative."[39]

Number Seven

The seventh difference is the nature of the doctor-patient relationship. "The doctor-patient relationship is the matrix of the family physician's diagnostic-therapeutic activity. To enhance the curative potential inherent in this relationship, the physician has to be able to make contact with the *person* in the patient."[40]

The family physician, from this wealth of experience, can develop what appears to be an almost intuitive diagnosis. "There is a sixth sense to provide information about the patient; the emotional experience evoked in the examining doctor by the attitude and bearing of the patient . . . The doctor's sixth sense is valuable in all consultations, but for the general practitioner it will, in many cases, be the only sense available to guide him to the correct diagnosis and management of the case. It should never be ignored although it need not be acted upon."[13]

I believe the family doctor-patient relationship is different for six reasons. Four reasons are presented above: tenured relationship, unselected patients with problems, the family as the unit of care and practice on a continuing basis. In addition the family doctor has an awareness of the whole patient in relation to his family and community, so he involves the family in diagnosis and management of patient problems more than other physicians. The sixth reason is that this relationship evolves throughout time. Patients choose their doctor in relation to what they want from a family physician. From this chosen beginning the family physician develops access to the family circle and a special position of trust. His relationship with any one member of the family is enlarged by his relationship with other family members and knowledge of their interrelationships.

Number Eight

This brings us to the eighth difference; the family practice counselling approach. Because of the "many strings of attachment"[32] with the patient and his family, the family physician is in the best position to counsel his patients most effectively and efficiently. I still believe that "the greatest therapeutic contribution the family physician can make in his own personality, and ability to relate to the patient."[41] A family doctor, for this reason, can "take considered risks with his patients, risks which cannot be taken by a psychiatrist. . .

"Events which could prove fatal in specialist practice can be taken by the general practitioner in his stride. When the psychotherapeutic relationship is broken off, he changes back into a doctor; then he becomes a psychotherapist again, then changes back into a doctor, and then into an obstetrician—having all sorts of intimate contacts with his patient which would be impossible to a psychiatrist—and finally turns into a 'friend of the family'."[32]

Deciding "what to treat" is one of the most important decisions in family practice. During visits for many different kinds of problems, the family doctor may become aware of a functional illness. "A 'functional' illness means that the patient has had a problem which he tried to solve with an illness. The illness enabled him to complain, whereas he was unable to complain about his original problem."[32]

Number Nine

The ninth difference is the whole person approach of the family physician. This approach sees the problem, illness, or disease in the total context of a patient with physical, emotional, and social attributes which cannot be separated from each other. The 'holistic' approach appreciates that all physical and organic conditions have emotional and social overtones in etiology, repercussions and management.

Number Ten

The family physician sees a different spectrum of problems from other physicians. The 17 most common presenting symptoms based on three Canadian studies have been ranked as follows:[42]

1. Sore throat
2. Abdominal pain
3. Cough
4. Headache
5. Nervousness
6. Fatigue
7. Rash
8. Chest pain
9. Back pain
10. Weight change
11. Dyspnea
12. Fever and chills
13. Depression
14. Regurgitation, vomiting
15. Nocturia, frequency
16. Dizziness
17. Anorexia

Problems present in family practice according to their incidence in the general population, with a high prevalence of chronic, emotional and transient illness.[10] Dr. Watts in his classic study has shown how depression presents in the community and how the family physician treats most of it himself. He clearly describes how psychiatric disorders and their problems are different in family practice from those encountered in the psychiatric hospitals and outpatient clinics.[43]

Number Eleven

The eleventh difference is the volume. Family practice is labor intensive: you have to do a lot more in order to increase your income. If a family physician sees 30 patients a day and loses two minutes with each patient because of some inefficiency in practice operation, then he has lost one hour that day and five hours for the week. This is just one reason why business administration and practice management techniques have become a recognized part of family medicine. Consultants spend more of their time in hospitals which provide the working materials and space through tax supported hospital budgets.

Number Twelve

Finally, family practices are different from each other.

Dr. Balint studied 14 practices and found them all to be quite different, largely due to the different personality, character and style of each physician. Patients change doctors, he believes, "according to the doctor's apostolic beliefs."[32]

A family practice also varies in relation to other physicians practicing in the community and their consulting disciplines; it varies with location, size of community and community resources as well as the community's expectations.

Another reason why family practices are different is that most family physicians had to learn the hard way, by trial and error. Most of our training was by consultants in hospitals, and after graduation we saw 90% of our patients in the office and in the home, with different sorts of problems. I am sure our training produced safe doctors, but I am not so sure how efficient and effective we were upon starting family practice.

The heterogeneity of family physicians is really impressed on you as an

examiner in the College of Family Physicians' certification exam process. It is really a delight to see the variegated approaches of experienced family physicians in solving the same clinical problem on the oral exam. I am sure this represents the same variety of problem solving that occurs in their daily practices. This is not surprising when we realize that family physicians have individually developed their problem solving methods in response to their practice experience in different communities.

On the other hand the traditional specialties of internal medicine, pediatrics, obstetrics and gynecology, etc., have well defined clinical methods and uniform programs of training and evaluation. Drs. Smith and McWhinney demonstrated this in their research which compared the diagnostic methods of family physicians and internists.[44]

I believe that in family practice you can have your cake and eat it too. It is possible to enjoy the breadth of medicine *and* develop special interests in relation to your community needs and your own talents.

Differences Between FPs and Other Primary Care Physicians

What's the difference between family practice and other primary care physicians? The most clear cut difference is that the others all limit the scope of their practices. Primary care internists do no surgery, no obstetrics, see no children. Primary care pediatricians exclude patients over 16 years of age while the obstetrician/gynecologist excludes all men and children.

TABLE 2

Differences Between Family Physicians and Other Primary Care Physicians (PCPs)

1. PCPs limit their practices so their problems are preselected.
2. PCPs have a higher referral rate.
3. This leads to fragmentation of patient care and division of responsibility.
4. Greater risk of polypharmacy and drug interactions.
5. PCPs do not take responsibility for the whole person.
6. PCPs have a different perspective: *disease* care related to their discipline.
7. PCPs use more lab and related tests.

The problems they see—and consequently the breadth of care they provide—are therefore preselected to a considerable extent.

A second difference between family physicians and other primary care physicians is their consultation and referral rates. "Rates of referral by family physicians in the United States and Great Britain average 2.5% with a range of 1.3-5.9%. Referral rates for internists range from 2.5-18% and for pediatricians, from 1.0-9.5%."[1]

These two differences lead to increased fragmentation of care and a division of responsibility. In communities where there are several different kinds of primary care physician, it is not uncommon for a family to have five or six physicians involved in their care. With so many powerful drugs available now there is greater risk of polypharmacy and drug interactions in families where this pattern of care exists. This is especially so when Drs. A & B do not know what Drs. C, D and E are doing or have prescribed. Who is in charge, who is responsible for the overall patient management? When there is a larger number of physicians involved there is much greater risk of what Dr. Balint called the "collusion of anonymity": "Vital decisions are taken without anybody feeling fully responsible for them."[32]

I believe this underscores another important difference: when patients and families go to other primary care physicians, no one has accepted responsibility for the care of the whole person or the total family.

Another significant difference of other primary care physicians is their perspective. Just about all of their training is in the hospital and most of the emphasis is on disease care as it relates to their specific discipline. There is very little emphasis on the whole person and the family. This difference is seen in their approach to the patient and his problem. Smith and McWhinney compared the diagnostic methods of family physicians and internists: "The results of this experiment show significant differences in the diagnostic approach of family physicians as compared with internists when the two groups were presented with three undifferentiated clinical problems. In summary, family physicians sought fewer items of information; asked fewer history questions; asked fewer questions about life situations and mental status in two of three cases, but their questions in these categories represented a greater proportion of the total history questions; asked fewer items of physical examinations; and ordered fewer laboratory and related tests."[44]

In order to clarify other differences between family physicians and other primary care physicians we need many more basic research studies of what family physicians do and how they function in the health care system. I believe Dr. Balint said it best when he wrote: "A real change for the better can be expected only as the result of longterm research into the pathology of the whole personality corresponding to what was described above as the deeper level of diagnosis. As the problems belonging to this field constitute *the* problem of general practice, no one but the general practitioner can undertake this research."[32]

The discipline of family medicine is here and the specialty of family practice has arrived! What we need now is more standardization of terms that describe more clearly what we *do*.

The difficulty of defining the fifth difference above demonstrates how one can get lost in our current terms. Armed with crisp, lucid terminology, we can carry out longterm studies into what we do to see how efficient and effective we are in rendering family care. ◉

References

1. Rakel RE: Principles Of Family Medicine. Toronto, W. B. Saunders Company, 1977, p. 536. 2. Medalie JH: Family Medicine—Principles And Applications. Baltimore, Williams & Wilkins Company, 1978, p. 372. 3. Hodgkin K: Toward Earlier Diagnosis—A Guide To General Practice, 3rd ed. New York, Churchill Livingstone, 1973, p. 729. 4. The Future General Practitioner—Learning and Teaching. Report of The Royal College of General Practitioners. London, British Medical Journal, 1972. 5. Fry J: Common Diseases: Their Nature, Incidence And Care. Toronto, J. B. Lippincott Company, 1974, p. 232. 6. McWhinney IR: The foundations of family medicine. Can Fam Physician 15:13-27, 1969. 7. McWhinney IR: An Introduction To Family Medicine. London, University of Western Ontario, 1970, p. 40. 8. Conn FC, Rakel RE, Johnson TW: Family Practice. Toronto, W. B. Saunders Company, 1973, p. 1093. 9. Carmichael L: Definition of the Family Physician. Presentation at the Conference on Training in Family Medicine, London, ON., May 1968. 10. McWhinney IR: An Introduction to Family Medicine. London, University of Western Ontario, 1970, p. 139. 11. McWhinney IR: Family medicine in perspective. N Engl J Med 293:176-181, 1975. 12. Rice DI: Family Practice training—A perspective. Can Fam Physician 14:41-51, 1968. 13. Browne K, Freeling P: The Doctor-Patient Relationship. Edinburgh, Chur-

Continued on page 1521

to the traditional SOAP format of problem oriented records a statement on the prognosis of the condition and how it was intended to follow up the prognostication, we would steadily accumulate information on the relationship of our medical processes to patient outcomes, and thereby assist in the validation or otherwise of the processes we use.

Whose responsibility is it to develop remedial educational programs? Again universities and academic colleges seem to be the logical bodies to develop such programs in sufficient variety, giving any practitioner the chance to correct any deficiency revealed by practice audit.

Conclusions

If we are to assure that quality care is provided, a number of steps will collectively remove most of the threat and provide the blessing of improved patient care. These steps are:

1. Standards of care must be set appropriate to the community's resources.
2. These standards must be described in terms of process and outcome criteria.
3. Outcome studies on patient cohorts will be needed to validate the efficiency of various processes of care for a variety of conditions seen in practice.
4. Validated process criteria, preferably in the form of criteria maps, should then be developed for a representative range of conditions, including psychosocial conditions.
5. Reliable and valid methods of quality assessment using these criteria should then be developed and applied. Chart review, observation, and peer group assessment are methods of practice audit which hold promise.
6. Remedial programs could then assist physicians in correcting any deficiencies revealed by the assessment process.
7. Follow up assessment will be needed to ensure that knowledge gained is applied in practice.

The emphasis throughout should be educational, not punitive.

What can universities and colleges do to facilitate these processes?

1. Conduct outcome studies to validate process standards.
2. Develop process criteria, especially criteria maps, for a wide range of conditions.
3. Emphasize strongly the importance of good records and provide training and assessment in this.
4. Encourage self-directed evaluation and build into training the concept and practice of regular assessment, with special emphasis on peer review.

If these challenges are accepted, the whole face of quality assessment will change. The motivation and impetus will come from the individual, not an outside agency.

I personally doubt the value of Professional Standards Review Organizations or any other type of externally imposed review system. That is a threat. What is needed is the motivation to review our standards of care which springs from within us because we really care for people. That will be the blessing. ◉

References

1. Clute KF: The General Practitioner. Toronto, University of Toronto Press, 1963.
2. Gonnella JS, Goran MJ, Williamson JW, et al: Evaluation of patient care—An approach. JAMA 214:2040-2043, 1970.
3. Pirsig RM: Zen And The Art Of Motorcycle Maintenance. Transworld Publishers Ltd., 1974, pp. 201.
4. Donabedian A: Promoting quality through evaluating the process of patient care. Med Care 6:181-202, 1968.
5. Komaroff AL: The PSRO, quality assurance blues. N Engl J Med 298:1194-1196, 1978.
6. Greenfield SH, Kaplan SH, Goldberg GA, et al: Physician preference for criteria mapping in medical care evaluation. J Fam Pract 6:1079-1086, 1978.
7. Brook RH: Quality—Can we measure it? N Engl J Med 296:170-171, 1977.
8. Clark MR, Putnam RW: An assessment of the impact of patient care appraisal on physician performance in an ambulatory setting. Mimeographed Grant Application, Halifax, Dalhousie University, 1977.
9. Nelson AR: Orphan data and the unclosed loop: A dilemma in PSRO and medical audit. N Engl J Med 295:617-619, 1976.
10. Brook RH, Appel FA: Quality of care assessment: Choosing a method for peer review. N Engl J Med 288:1323-1329, 1973.
11. Smith SR: Application of the tracer technique in studying quality of care. J Fam Pract 4:505-510, 1977.
12. Kane R, Hogben M: Teaching quality of care assessment to medical students. J Med Educ 49:778-780, 1974.
13. Cooper JAD: Medical education and the quality of care. J Med Educ 51:363-364, 1976.
14. The Birmingham Research Unit of the RCGP: Self evaluation in general practice. J R Coll Gen Pract 27:265-270, 1977.

Continued from page 1487

chill Livingstone, 1976. 14. Marinker M: Albert Wander Lecture. Proceedings of Royal Society of Medicine. 69:115-124, 1976. 15. Werkman SL, et al: The common psychiatric problems in family practice. Psychosomatics 17:119, 1976. 16. Kellner R: Family Ill Health. London, Tavistock Publications Ltd., 1963. 17. Litman TJ: Health care and the family: A three generational analysis. Med Care 9:67-81, 1971. 18. Smilkstein G: The family in trouble—How to tell. J 73Fam Pract 2:19-24, 1975. 19. Minuchin S: Families And Family Therapy. Cambridge, Mass., Harvard University Press, 1974, p. 268. 20. Robb DM: Personal Communication, Hampton, NB. 21. International Encyclopedia of the Social Sciences. 5:301, 1968. 22. Willard WR: Meeting The Challenge of Family Practice. Report of the Ad Hoc Committee on Education For Family Practice of the Council on Medical Education. Am Med Assoc., 1966, p. 9. 23. Pellegrino ED: The academic viability of family medicine. JAMA 240:132-135, 1978. 24. Hennen BKE: Family medicine: The discipline. Can Fam Physician 25:65-69, 1979. 25. Committee on Educational Objectives: Canadian Family Medicine, Educational Objectives for Certification in Family Medicine. Willowdale ON. College of Family Physicians of Canada, 1974, p. 36. 26. Brown DC, Kuch JH: Role and function of the family physician as it relates to the whole physician treating the patient as a whole person with emphasis on anticipatory guidance. Scientific Exhibit at the Tenth Annual Spring Conference of the Society of Teachers of Family Medicine, Atlanta, Georgia, May 1977. 27. Vinger I: Health promotion—The family physician's responsibility. Can Fam Physician 18:73-75, 1972. 28. Vinger I: The family physician as health educator. Primary Care 1:263-273, 1974. 29. Fisher JV, Mason RL, Fisher JC: Emotional illness and the family physician. Part I, Identification & diagnosis. Psychosomatics 16:55-58, 1975. 30. Hopkins P: Patient-Centered Med&cine. London, Regional Doctor Publications Ltd., 1972. 31. Ireton HR, Cassata D: A psychological systems review. J Fam Pract 3:155-159, 1976. 32. Balint M: The Doctor, His Patient And The Illness. New York, International University Press, 1957, p. 355. 33. Collyer JA: A measure of a family doctor's work. Part I: Setting up a one-practice study. Can Med Assoc J 112:1256-1260, 1975. 34. Stanford BJ: Counselling a prime area for family doctors. Am Fam Physician 5:183-185, 1972. 35. McWhinney IR: Beyond diagnosis: An approach to the integration of behavioral science and clinical medicine. N Engl J Med 287:384-387, 1972. 36. Hennen BKE: Continuity of care in family practice. Part I: Dimensions of continuity. J Fam Pract 2:371-372, 1975. 37. Hopkins P, Clarke BS: Patient-Centered Medicine. Development Of Long-Term Relationships in General Practice. London, Regional Doctor Publication Ltd, 1972, chap. 31, p. 209. 38. Brown DC: Family Counselling in General Practice. Paper delivered at WONCA Meeting, Montreux, Switzerland, May 1978, Der Praktische Artzt, 16 June, 1979, p. 2518. 39. McWhinney IR: The Future of Family Medicine. Address delivered at CFPC 25th Anniversary Meeting, Ottawa, May 1979. 40. Ornstein PH: The Family Physician as a "Therapeutic Instrument". Paper presented at 1976 Annual Workshop for Directors of Family Practice Residency Programs, Kansas City, June 8, 1976. 41. Brown DC: Dalhousie University's new family medicine centre. Can Fam Physician 16:75-79, 1970. 42. Committee on Educational Objectives: Canadian Family Medicine Educational Objectives for Certification in Family Medicine. Willowdale ON, College of Family Physicians of Canada. 1974, p. 44. 43. Watts CAH: Depressive Disorders In The Community. Bristol, John Wright & Sons, Ltd., 1966, p. 174. 44. Smith DH, McWhinney IR: Comparison of the diagnostic methods of family physicians and internists. J Med Educ 50:264-270, 1975.